

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012229</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/05/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTH AT JUDAY CREEK LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6330 N FIR RD</b> <b>GRANGER, IN 46530</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00183204.</p> <p>Complaint IN00183204 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey date: November 5, 2015.</p> <p>Facility number: 012229 Provider number: 012229 AIM number: N/A</p> <p>Residential census: 125</p> <p>Sample: 3</p> <p>Hearth at Juday Creek LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00183204.</p> <p>QR completed by 14454 on November 13, 2015.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE